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Framing Mental Illness, 1923–1939: The Maudsley Hospital and its Patients

Edgar Jones and Shahina Rahman*

Summary. British psychiatric care during the inter-war period has often been characterised in bleak and even punitive terms: an asylum system that required certification for treatment, radical and often risky clinical interventions of no established benefit to patients and a lack of empathy or creativity among doctors. Although the Maudsley Hospital was designed to break the asylum mould, the received view is that a distinctive admissions policy targeted those with a good prognosis, excluding the unruly and chronic. Using random samples drawn from 1924, 1928, 1931, 1935 and 1937–8, this paper explores how changing hypotheses about mental illness influenced the selection and management of Maudsley patients. The largest single diagnosis for in-patients was depression, although 24 per cent had a psychotic disorder. Almost all in-patients resided in Greater London. Only 13 per cent were unskilled workers, 30 per cent being from the professional class. While the key to understanding mental illness was thought to lie in the young, the in-patient population was largely middle-aged. In its operation, the Maudsley did not adhere to the founders' strategic plan but, in the absence of effective treatments, focused on the provision of a changing and varied patient population for its growing army of trainees and researchers.

Keywords: insanity; mental illness; neurosis; psychological disorders; psychiatric patients; psychosis; treatment

The admissions policy of the Maudsley Hospital during the inter-war years is often characterised as one in which the demands of its postgraduate medical school took precedence over the needs of local people who suffered from major mental illness.¹ Jones described the Maudsley as a centre for 'the treatment of the neuroses of a peace-time economy'.² Bennett observed that it only took 'responsibility for the surrounding catchment area, including chronic patients, 50 years after the hospital had pioneered early and voluntary treatment of selected patients'.³ Indeed, at the 1926 meeting of the British Medical Association's Neurology and Psychiatry section, E. Farquhar Buzzard challenged Edward Mapother, Medical Superintendent of the Maudsley, over his claim that no clinical basis could be found to justify the distinction between neuroses and psychoses.⁴

Thomas Ross of the Cassel Hospital even suggested that this blurring was a justification for the Maudsley's admissions policy, which effectively blocked chronic cases of severe mental illness, while opening the door to 'a very small section of the psychoneurotic

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¹Shorter 2005, p. 170.

²Jones 1972, p. 235.

³Bennett in Berrios and Freeman (eds) 1991, p. 328.

⁴Mapother 1926, p. 877.

group'.⁵ In his defence, Mapother argued that the Maudsley was the only hospital in the UK in which it was 'possible to get simultaneous experience of both extremes in mental disorder and of the intermediate cases that were the crux of this question'.⁶

No objective evidence has been published about the epidemiology of the hospital's early patients. Aubrey Lewis, who worked at the Maudsley from 1928 and became its clinical director in 1936, recorded little about admissions during these formative years, while later studies made only passing reference to the nature of the clinical workload in the hospital.⁷ In this paper, we seek to clarify the characteristics of the Maudsley's patient population, in particular their geography, social origins, ages and diagnoses, in an attempt to understand the strategy of Mapother and his senior colleagues.

Funded by the London County Council (LCC) and supported by increasingly generous grants from the Rockefeller Foundation, the Maudsley's distinctive admissions policy served to create the impression that patients were not only carefully selected and offered special treatment, but also represented the 'cream' of the mentally ill. Under the terms of Henry Maudsley's endowment, the hospital was committed to 'the early treatment of cases of acute mental disorder, with the view as far as possible, to prevent the necessity of sending them to the county asylums'.⁸ Maudsley believed that psychotic disorders could be 'cured' if caught early and subjected to 'individual treatment, mental and medical' in an institution freed from stigma. The other architect of the scheme to devise a new way of treating the mentally ill was Frederick Mott, a distinguished neuropathologist and director of the LCC's Central Pathological Laboratory.⁹ Having experienced the asylum system at first hand while based at Claybury in Essex, Mott was determined to establish a hospital that could serve the needs of a postgraduate medical school: a central London location to facilitate access, teaching and research facilities, together with beds for the short- and medium-term occupancy of patients with a wide range of disorders.¹⁰

The clinical agenda set for the Maudsley was also influenced by on-going debate about the nature and causes of mental illness. Mott believed that the symptoms of dementia praecox and manic-depressive disorder were the consequence of a degenerative process. A card index of patients and their relatives had led Mott to conclude that heredity played a key role in these disorders.¹¹ Furthermore, his 'law of anticipation' suggested that the children of sufferers not only developed the illness earlier than their parents but in a more severe form.¹² By the time a patient's mental state had deteriorated

⁵Mapother 1926, p. 878.

⁶Mapother 1926, p. 879.

⁷Shorter 2005; Lewis 1969; Allderidge in Berrios and Freeman (eds) 1991; Anon. 1974; Jones in Angel *et al.* (eds) 2003.

⁸London Metropolitan Archives (LMA), Published Minutes of the London County Council, 18 February 1908, p. 282.

⁹Meyer 1973, pp. 499–501.

¹⁰Mott 1907, pp. v–vi; Mott 1909, p. iii.

¹¹Hayward in Roelcke and Weindling (eds) 2008, (in press).

¹²Mott 1911. Subsequently, Mott's 'law of anticipation' was criticised by geneticists, including Lionel Penrose, Professor of Human Genetics at University College London. Recent research, however, has shown that his observations were accurate.

to a point that justified certification—the compulsory removal of an individual's right to freedom of movement—then the disease was often so advanced, Mott argued, that it could no longer be treated.

It was crucial to catch disorders in their 'prodromal' or initial stages.¹³ Hence, in 1921, when finalising the hospital's terms of reference, the Asylum Sub-Committee of the LCC sought to restrict admissions to those 'suffering from incipient mental disease' by excluding anyone who had been certified as suffering from a major psychiatric disorder.¹⁴ On being appointed medical superintendent, Edward Mapother refined the admissions policy, further declaring in February 1923 that the Maudsley Hospital would target:

neuroses (hysteria of various forms, neurasthenia, anxiety and obsessional states), and certain varieties of psychoses, e.g. mild phases of the manic-depressive type, psychoses associated with exhaustion, with pregnancy and the puerperal period, with post-infective states, with syphilitic brain disease of the interstitial types, with alcoholisms and other drug habits, with endocrine disturbances, and generally cases exhibiting mental symptoms associated with all forms of definite bodily disease.¹⁵

Significantly, Mapother did not mention dementia praecox or schizophrenia, both established terms. This agenda, combined with rules that allowed the hospital to exclude unruly and chronic patients, created the impression that the Maudsley would filter all patients except those with a good prognosis.¹⁶

Clinical Agenda

Given the strictures of the asylum system and the scale of the problem, psychiatry presented fertile ground for promising claims. British mental institutions held 130,300 certified in-patients in 1919, a figure that was set to rise to 150,300 by 1934.¹⁷ Much could be achieved both clinically and financially if an effective medicine or surgical procedure could be found to tackle the symptoms of major mental illness. The professional rewards that would attach to any doctor who pioneered such a breakthrough were almost irresistible. A number of influential psychiatrists, such as Adolf Meyer, believed that if the discipline were to integrate itself within medical science and the universities, striking clinical gains would follow.¹⁸

The focal sepsis claims of Henry Cotton, Medical Director of the New Jersey State Hospital, Trenton, can be understood within this context.¹⁹ In June 1923, Cotton travelled to London at the invitation of the Medico-Psychological Association to address their summer meeting, his presentation being published in the October issue of the *Journal of Mental Science*.²⁰ Cotton argued that pus infection, whether in the colon, tonsil, teeth or

¹³Mott 1903, pp. ix, xi; Mott 1907, p. v.

¹⁴Lewis 1969, p. 1354.

¹⁵Mapother 1923.

¹⁶Jones *et al.* 2007.

¹⁷Jones 1972, p. 358; Fuller Torrey and Miller 2001, p. 94.

¹⁸Pressman 1998, pp. 18–21.

¹⁹Scull 2005.

²⁰Cotton 1923.

elsewhere in the body, caused microscopic lesions in the cerebral cortex, which healed when the sepsis was treated. Cure of mental illness lay with the elimination of 'chronic sepsis'. As a result, physicians and surgeons were employed at Trenton to eradicate infection, often involving the removal of the appendix, teeth, tonsils and sections of the gastric and genito-urinary tracts. Having 'cleaned' his patients of infection, Cotton claimed that the 'recovery-rate' for the five years to 1922 rose to 87 per cent, compared with 38 per cent over the previous decade. The saving to the state, he estimated, ran to a million dollars.²¹ Such failures as he encountered were attributed to delay in treatment 'upon the ground that the brain has become permanently damaged, and no amount of detoxication can restore the damaged brain-cells'.²² This causal model allowed Cotton to relegate hereditary and psychogenic factors to minor roles.

In the UK, Cotton received praise from Frederick Mott, who declared at the Medico-Psychological Association meeting that:

at the present time there were a considerable number of cases of bowel disease—ulceration of the bowel—from typhoid, paratyphoid, and dysentery—infectious diseases which many of the subjects of them acquired in the asylum. Was it right, then, if this was a cause of chronic sepsis, of septic absorption, not to take every precaution to prevent these diseases becoming epidemic, or even endemic, in asylums?²³

Support from Mott was forthcoming, in part, because of an urgent need for treatment but also because he had identified a similar mechanism for general paralysis of the insane (GPI). His histological research had shown that some psychotic presentations had an organic basis in the neurological effects of tertiary syphilis. Malarial fever therapy, pioneered in the early 1920s, that killed the spirochete effectively ended this severe and disabling disorder.²⁴ In view of the prevalence of mental illness, it was hypothesised that if other pathological processes lay at the root of mental illness, these had to involve common diseases such as tuberculosis, dysentery or pneumonia.

The ambitious claims of Cotton stood in stark contrast to the established theories of Emil Kraepelin. Not only did the latter believe that major mental illness ran in families, suggesting a genetic element, he also characterised symptoms as the outward expression of degenerative neurological disease. For this reason, Kraepelin adopted the diagnostic label 'dementia praecox'.²⁵ Although his ideas, developed in the 1890s, were slow to gain adherents in the UK, by the outbreak of the First World War they had won a place in textbooks and teaching.²⁶ Indeed, the term dementia praecox was routinely employed by Maudsley psychiatrists in 1923 and 1924, although it had been supplanted by Bleuler's term 'schizophrenia' by 1928.²⁷ If Kraepelin were right that dementia praecox and manic-depressive illness represented a definite disease process in the brain, then

²¹Cotton 1923, p. 459; Scull 2005, pp. 71, 73.

²²Cotton 1923, p. 460.

²³Mott 1923, p. 558.

²⁴Grob 1983, p. 293.

²⁵Turner in Freeman (ed.) 1999, pp. 12–13.

²⁶Jon and Beer 2002.

²⁷Bethlem Royal Hospital Archives (BRHA), random sample of in- and out-patient notes for 1928.

research was needed to document the progress of the disease, to find out which groups of patients it affected and why.

In 1925, an alternative but optimistic hypothesis was advanced by Humphry Rolleston, professor of physic at Cambridge and president of the Royal College of Physicians. He proposed that hereditary factors, hitherto assumed to be present at birth, might be acquired in early youth as a result of family influences. Alternatively, they could remain dormant until awakened by exciting factors such as physical trauma, infection, toxins, unhealthy environment, diet or psychological triggers such as 'worry, emotional strain, overwork'.²⁸ Mott himself continued to believe in the importance of hereditary factors and quoted the low rate of mental illness (0.05 per cent) found among 10,000 Serbian prisoners-of-war:

They must be a very sturdy people; probably all who were not sturdy had been eliminated by army tests . . . there were people who could go through syphilis, typhoid and other diseases; who could indulge freely in alcohol, who could be given a blow on the head, and yet pass through all this without becoming insane.²⁹

Mott remained committed to an hereditary position up to his death in 1926 but became increasingly convinced that common diseases such as tuberculosis, pneumonia and dysentery served as triggers in those with a genetic predisposition to mental illness.³⁰

Doctors who had treated shell-shocked soldiers during the First World War were also optimistic. Many of these patients had no history of mental illness and had functioned well before their enlistment.³¹ Army physicians concluded that the trauma of combat had activated hereditary traits hitherto dormant. Indeed, Arthur Brock at Craiglockhart argued that the dissociative process at the root of shell shock had a physical counterpart, which in part explained the increase in 'cancer, tuberculosis and other diseases of civilization'.³² There seemed little reason why a similar process might not lie at the root of schizophrenia or mania.

An innovative study by John Carswell conducted in a fifty-bed observation ward attached to the Eastern District Hospital in Glasgow supported this hopeful hypothesis. Permission had been granted to admit psychiatric patients on a voluntary basis without certification to trace the 'occurrence of insanity'.³³ Carswell found that of the 6,376 patients treated between 1904 and May 1914, 40.7 per cent were discharged as fully recovered, while only 35.9 per cent had to be certified and committed to an asylum because of continuing or severe mental illness.³⁴ Furthermore, of the 909 first-episode cases admitted between 1911 and 1913, his analysis suggested that 67 per cent of those falling ill between the ages of 15 and 45 were the result of a 'morbid biogenetic element' that had been triggered by an external event; the remaining 43 per cent, he believed, had an organic basis, such as syphilis, alcohol or neurological disease.³⁵ If this

²⁸Rolleston 1925, p. 782

²⁹Mott 1923, p. 557.

³⁰Mott 1924, p. 528.

³¹Stone in Bynum *et al.* (eds) 1985.

³²Cantor 2005, p. 11.

³³Carswell 1924, p. 349.

³⁴Carswell 1924, p. 354.

³⁵Carswell 1924, pp. 347, 355.

hypothesis were true, then much mental illness was preventable or treatable if caught in its early stages. At first, the new discipline of psychological medicine appeared to offer considerable clinical gains.³⁶

The Maudsley Patient Population

In the early years at least, before patient numbers became too large, Mapother exercised control over patient admissions. C. P. Blacker, an assistant medical officer at the Maudsley in 1927, recalled being compelled to attend Mapother's mid-morning case conference when juniors presented preliminary assessments.³⁷ Both Lewis and Blacker found these meetings irksome, not only because of the time involved but also because Mapother would already have discussed new or problematic patients with Miss Walker, the matron, whom he met as soon as he arrived at the hospital. It was thought that she exercised too great an influence, having had the first opportunity to brief him.³⁸

The number of cases admitted to the Maudsley or seen as out-patients during the inter-war period rose as the hospital's reputation and income grew. For the first nine years of the hospital's operation, patient numbers were audited (Table 1). Thereafter, continued expansion and increased specialisation rendered the production of these statistics problematic.

To generate representative pictures of the patient population, samples were selected using a random-number generator. Case notes were filed alphabetically by year of discharge. We selected 1924, 1928, 1931 and 1935 for investigation to avoid missing records and to provide a perspective across the inter-war period. In total, 1,172 patients were studied (Table 2). The difference in the number of patient contacts (Table 1) and the number of case notes for any given year is largely explained by multiple consultations in various settings. Patient notes were the primary source for all years apart from 1937–8. The closure of the Maudsley and the transfer of its staff to Emergency Medical Service hospitals at Mill Hill and Sutton during the war years led to their loss for the period 1936–9. To fill this gap, discharge summaries were used, although only a small number survived and all cases were included.

Because of the emphasis on heredity and the need to gather data for research, clinical notes were detailed, containing biographical details, symptoms, treatment and follow-up evidence. William Sargant recalled collecting over 30 pages of information on one patient. In the absence of effective interventions, he suggested that such exercises 'gave us a feeling that we were doing something for the patient by learning so much about him, even if we could not yet find any relief for his suffering'.³⁹ On admission, patients had a thorough physical examination in the belief that mental disorder might be associated with infectious disease but also because a significant number had a recognised physical illness.⁴⁰

³⁶Mayou 1989.

³⁷Lewis 1970.

³⁸Blacker 1960, p. 5.

³⁹Sargant 1967, p. 36.

⁴⁰Scull 2005.

Table 1. The patient population of the Maudsley Hospital, 1923–1931

	Out-patient consultations		In-patient admissions			Total number of patients treated
	Adults	Children	Adults	Children	Private patients	
1923	850	44	418	8	36	1,012
1924	989	56	500	34	56	1,304
1925	1,252	57	598	42	48	1,566
1926 ^a	1,147	61	581	45	71	1,505
1927	1,269	121	707	24	66	1,703
1928	1,588	161	693	39	64	2,225
1929	1,580	176	663	34	50	2,208
1930	1,711	200	671	40	58	2,394
1931	1,965	432	NA	53	NA	2,761

Note: The total number treated is less than the sum of total out-patients and in-patients because some subjects initially seen in out-patients were subsequently admitted to the wards and discharged patients were followed up as out-patients.

^a Eleven months only.

Source: Bethlem Royal Hospital Archives (BRHA), C/12/4 Mapother Box 13.

Table 2. Maudsley Hospital: random samples of case notes, 1924–1937/8

	1924	1928	1931	1935	1937/8	Total
Adult in-patients	100 (320)	100 (405)	100 (404)	100 (516)	29 (29)	429 (1,674)
Adult out-patients	75 (132)	75 (351)	75 (1,011)	75 (973)	96 (96)	396 (2,563)
Child in-patients	15 (15)	19 (19)	22 (22)	19 (19)	4 (4)	79 (79)
Child out-patients	15 (15)	43 (43)	50 (153)	50 (372)	110 (110)	268 (693)
Total	205 (482)	237 (817)	247 (1,590)	244 (1,881)	239 (239)	1,172 (5,009)

Note: Figures in brackets are the total number of surviving case notes.

Source: Maudsley Patient Case Notes, BRHA.

A database was created using ACCESS and to preserve confidentiality anonymised information was extracted from case notes using a standard form. The study had been approved by the ethics committee of the South London and Maudsley NHS Trust and its Caldicott Guardian, while access was strictly defined by the Bethlem Royal Hospital Archives to whom Maudsley notes had been entrusted. Only files with substantial missing data were excluded. Because patient records are ‘artefacts of the interaction between physicians and their patients in which individual personality, cultural assumptions, social status, bureaucratic expediency, and the reality of power relations are expressed’,⁴¹ no attempt was made to reclassify disorders using modern categories.

⁴¹Risse and Warner 1992, p. 189.

Diagnosis

Table 3, an analysis of adult in-patients by diagnosis, shows that the Maudsley did not limit itself to incipient insanity or to neurotic disorders. In 1924, for example, 35 per cent of admissions were diagnosed with dementia praecox, schizophrenia, mania or other psychoses. For the entire sample, 24.5 per cent of adult in-patients suffered from major mental illness that included a psychotic element. However, the largest single diagnosis was depression (37.5 per cent). Anxiety states, conversion disorders and neuroses represented only 22.4 per cent of admissions. Organic states, such as epilepsy, dementia or cerebral tumour, accounted for 13 per cent of admissions.

No equivalent studies have been undertaken of patients treated in the various LCC asylums constructed in the London suburbs to enable proper comparison. However, the fact that these mental hospitals were legally obliged to admit only certified cases implies that the proportion of subjects with major mental illness (schizophrenia, manic-depression and other psychotic disorders) was much higher. Until comparative statistics are available, we have to rely on anecdotal accounts and surmise. Henry Rollin, who took the Diploma in Psychological Medicine course at the Maudsley in the late 1930s while working at Caterham Mental Deficiency Hospital, recalled 'mental hospitals pre-1939 were in effect total institutions: the patient population was relatively static; security was tight and, as a result, contact with the outside world was tenuous to say the least'.⁴²

To what extent, then, did diagnostic criteria influence the Maudsley's admissions policy? Publicly, Mapother argued that the nosological division between psychotic and neurotic disorders was merely a legal one relating to the issue of certification, declaring that he could 'find no other basis for the distinction'.⁴³ In addition, he argued that the differences between manic-depressive psychosis and dementia praecox were 'only questions of constancy and degree'.⁴⁴ Eliot Slater, who came to the Maudsley as a junior doctor in 1931, recalled being taught that patients were conceived as:

a psychobiological unity, unique, to be anatomized and classified at one's peril. Neuroses and psychoses shaded into one another; the distinction between them was arbitrary, misleading and almost meaningless. Diagnosis was of little service. To distinguish a patient as suffering from a schizophrenic or an affective state was often a labour lost, since both conditions could so easily co-exist in the same individual, and neither was more than a mode of 'reaction'.⁴⁵

The reality, as practised by Mapother, was somewhat different. Desmond Curran, like Slater a junior psychiatrist, had studied Meyer's approach at the Phipps Clinic while on a Rockefeller fellowship to the USA. He recalled that Meyer might comment on a patient with long-standing schizophrenia: 'we must recognize that the therapeutic possibilities of this case are limited'. By contrast, 'Mapother would just say, smacking his palm, "a stiff praecox"',⁴⁶ the terse phrase 'providing an epigrammatic summary of his

⁴²Rollin 1990, p. 13.

⁴³Mapother 1926, p. 872.

⁴⁴Mapother 1926, p. 874.

⁴⁵Slater 1960, p. 7.

⁴⁶Curran 1960, p. 5.

Table 3. Maudsley Hospital adult patients by diagnosis, 1924–1937/8

Diagnoses	1924				1928				1931				1935				1937/8				Total	
	Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		In	Out
	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out		
Dementia praecox/schizophrenia	10	6	6	4	5	4	10	3	5	10	7	3	7	3	10	5	2	6	4	6	66 (15.4)	50 (12.6)
Manic-depression	2	0	6	1	1	0	1	0	1	0	1	1	2	0	0	0	0	0	1	1	15 (3.5)	3 (0.8)
Other psychoses	0	3	11	1	3	1	3	3	2	4	3	4	0	1	2	0	0	0	0	1	24 (5.6)	18 (4.5)
Depression	10	3	19	12	18	13	22	12	12	4	31	13	8	9	28	16	5	3	8	15	161 (37.5)	100 (25.2)
Anxiety disorder	3	4	5	9	5	3	5	6	2	4	4	5	6	8	7	6	1	7	2	30	40 (9.3)	72 (18.2)
Obsessive disorder	2	2	2	0	1	3	0	1	0	1	0	0	1	2	0	1	0	0	0	1	6 (1.4)	11 (2.8)
Other neuroses	3	5	5	18	4	5	13	5	3	7	6	11	8	2	4	7	2	9	2	15	50 (11.7)	85 (21.5)
Organic disorders	6	3	8	1	7	7	1	4	10	1	5	5	10	5	7	8	0	7	2	4	56 (13.1)	45 (11.4)
Unknown	0	0	2	3	1	0	0	5	1	1	7	1	0	0	0	2	0	0	0	1	11 (2.6)	12 (3.0)
Total	36	26	64	49	45	36	55	39	36	32	64	43	42	30	58	45	10	32	19	64	429 (100)	396 (100)

Source: Maudsley Patient Case Notes, BRHA. Age and Gender.

opinion on aetiology, course and prognosis'.⁴⁷ This example suggests that Mapother's pre-war experience at Long Grove Asylum had led him to conclude that chronic schizophrenia had an intractable quality and hence the need to select patients from the 'intermediate' category; that is, those in whom psychotic disorder was mild or incipient. This, too, would explain his claim that in the early stages of psychosis no fundamental distinction could be drawn between the condition and a neurotic disorder.

Cultural and institutional biases made women particularly vulnerable to the asylum system during the inter-war period.⁴⁸ Whereas they had represented 58.5 per cent of admissions to mental institutions in England and Wales in 1907, this proportion rose to 69.4 per cent by 1937.⁴⁹ This gender difference was reflected in the Maudsley's in-patient population, 39.4 per cent of the sample being male and 60.6 per cent female, the same proportion being recorded for out-patients (Table 3). However, the disparity was even more marked at the Bethlem where 69.4 per cent of admissions were women in 1937.⁵⁰

Despite the Maudsley's strategic aim of treating the young in whom mental illness was incipient, Table 4 shows that most adult patients were middle-aged. The mean age of in-patients in the sample was 37.3 for females and 41.5 for males, while out-patients were 38.3 and 36.2 respectively. Those aged between 16 and 20 years were relatively uncommon: only 5.6 per cent of in-patients and 9.9 per cent of out-patients. Many more fell within the age range 21 to 30: 28.5 per cent of in-patients and 27.9 per cent of out-patients. Those aged between 31 and 60 constituted the bulk of the Maudsley's population: 57.2 per cent of in-patients and 54.8 per cent of out-patients. Although no specialist old-age service was set up, 8.6 per cent of in-patients and 7.9 per cent of out-patients were aged between 61 and 80.

Because so much general illness was then untreatable, most deaths were from common diseases rather than self-harm. In-patient mortality ranged from 18 in 1926 to 41 in both 1927 and 1929. The death-rate for 1931 was recorded as 10.2 per cent for men and 5.6 per cent for women.⁵¹ Death by suicide was reported as being significantly lower than that from heart failure or pneumonia.⁵²

Social Class and Geographical Distribution

Contrary to received wisdom, the Maudsley did not focus exclusively on middle-class patients. However, grouped according to the 1911 Census classification,⁵³ 30.1 per cent of male in-patients and 12.8 per cent of out-patients were from the professional class (Table 5). Most male in-patients (48 per cent) fell within classes II, III and IV—intermediate (butchers, bakers, grocers, shop-keepers, salesmen, publicans), class III skilled (carpenters, hairdressers, electricians, gas fitters, printers, tailors, drivers) and class IV semi-skilled (messengers, postmen, tanners, warehousemen, grooms, policemen,

⁴⁷Slater 1960, p. 8.

⁴⁸Showalter 1987, p. 3.

⁴⁹Andrews *et al.* 1997, p. 657.

⁵⁰*Ibid.*

⁵¹National Archives (NA) MH95/32 Visit of the Board of Control on 8 July 1932, p. 7.

⁵²NA MH95/32 Annual Reports on the Maudsley Hospital by the Inspectors of the Board of Control (1923–48); Report by B.T. Hodgson and A. Rotherham, 16 December 1924, p. 1.

⁵³Szreter 1996, pp. 608–13.

Table 4. Age ranges for adult Maudsley Hospital Patients, 1924–1937/8

Age ranges	1924				1928				1931				1935				1937/8			
	In-patients		Out-patients		In-patients		Out-patients		In-patients		Out-patients		In-patients		Out-patients		In-patients		Out-patients	
	M	F	M	F	M	F	M	F	M	F*	M	F	M	F	M*	F	M	F	M	F*
16–20	3	3	4	2	2	5	6	7	1	7	3	4	0	3	1	5	0	0	5	2
21–30	9	21	12	19	10	15	5	10	9	16	11	6	6	25	9	15	1	10	8	13
31–40	4	18	5	14	9	14	11	7	8	14	6	8	16	12	9	10	5	4	6	19
41–50	7	11	2	7	13	8	6	10	9	11	6	13	8	12	4	9	3	1	7	12
51–60	9	7	2	4	6	5	4	2	6	8	4	6	9	4	4	4	1	3	4	11
61–70	4	4	1	2	3	8	2	1	2	6	2	5	3	2	2	2	0	1	2	5
71–80	0	0	0	1	2	0	2	2	1	1	0	1	0	0	0	0	0	0	0	1
Total	36	64	26	49	45	55	36	39	36	63	32	43	42	58	29	45	10	19	32	63

Note: ^a One patient for whom no age is recorded.

Source: Maudsley Patient Case notes, BRHA.

Table 5. Maudsley hospital patients: males by occupation, 1924–1937/8

	1924		1928		1931		1935		1937/8		Total	
	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
I. Professional	14	5	18	5	11	5	7	4	1	1	51 (30.1)	20 (12.8)
II. Intermediate	2	3	5	6	9	8	12	4	3	10	31 (18.3)	31 (19.9)
III. Skilled	7	6	6	9	4	6	13	7	2	3	32 (18.9)	31 (19.9)
IV. Semi-skilled	6	4	5	5	4	2	2	3	1	6	18 (10.7)	20 (12.8)
V. Unskilled	2	4	6	6	5	7	7	7	2	10	22 (13)	34 (21.8)
Unknown	5	4	5	5	3	4	1	5	1	2	15 (8.9)	20 (12.8)
Total	36	26	45	36	36	32	42	30	10	32	169 (100)	156 (100)

Source: Maudsley Patient Case-notes, BRHA.

caretakers). Unskilled workers (labourers, porters and watchmen) represented only 13 per cent of in-patients and 21.8 per cent of out-patients, probably a consequence of the belief that those of low intelligence or limited educational achievement had a worse prognosis. Given the background population of Greater London, these figures suggest a bias in favour of middle-class patients. Nevertheless, the Maudsley distribution was broader than that recorded at a means-tested, charitable asylum, such as the Bethlem where for 1911–15, 60.9 per cent of admissions fell within social class I and only 8.8 per cent were semi-skilled or unskilled workers.⁵⁴

The social class of females could not be assessed as most were recorded as housewives or living with parents. For the minority that were employed, common occupations amongst the in-patient population included: domestic, typist, nurse, shop assistant and tailor.

Established as a centre of national excellence and located within four miles of Charing Cross Station to facilitate access,⁵⁵ it was expected that Maudsley patients would show a wide geographical distribution across southeast England. This was not the case. For 1924, most in-patients (51 per cent) lived within four miles of the hospital, while 40 per cent came from within Greater London (between 4 and 20 miles) and only 7 per cent from beyond (2 per cent of addresses were not recorded). An analysis conducted in 1926 showed that 54 per cent of patients had been referred by GPs, 15 per cent came from other hospitals and only 3 per cent from asylums.⁵⁶ In part, this was a funding issue. The LCC paid the costs of anyone admitted who resided within its boundary, while those living elsewhere were charged a weekly fee of £5.00. The Asylum Sub-Committee, which monitored patient returns from the Maudsley, would have recorded its disapproval if the hospital were seen to be admitting a significant number of patients from beyond the boundaries of the LCC.⁵⁷

By 1935 the picture had not altered appreciably: 39 per cent of in-patients lived within 4 miles of the Maudsley, 53 per cent between 4 and 20 miles and 8 per cent more than 20

⁵⁴Andrews *et al.* 1997, p. 660.

⁵⁵Jones *et al.* 2007.

⁵⁶BRHA C12/4 Mapother Box 13, 'Appeal for the endowment of an Institute of Psychiatry', p. 9.

⁵⁷LMA LCC Published Minutes, Statistics of voluntary boarders at the Maudsley Hospital.

miles. The increase in the proportion from Greater London was a consequence of the opening in 1932 of three north London out-patient clinics (set up at Mile End Hospital, Bancroft Road, St Mary's Hospital in Highgate and at St Charles' Hospital in Ladbroke Grove), which served to feed the in-patient population.⁵⁸ These had been set up because an out-patient survey had shown that 'a high concentration' lived 'within a zone having a radius of two miles from the Maudsley'.⁵⁹

Trainee Psychiatrists, Researchers and the Maudsley Model

Because clinical expectations had been raised during the early 1920s, as Aldwyn Stokes recalled, 'the leaders of medicine were advising good young men to take up psychiatry (psychological medicine) as a field of great specialist opportunity'.⁶⁰ Mapother sought young doctors who had trained in general medicine and neurology, rather than psychiatry, to encourage new ideas: 'they were given temporary appointments in the hospital and were encouraged to go their own way, learning their psychiatry from the bedside more than from books or lectures'.⁶¹ With ever-growing numbers of trainee psychiatrists, many from overseas, studying for the Diploma in Psychological Medicine (DPM) or doctorates,⁶² it was important to provide them with a regular turnover of varied case material. To maintain their interest and provide material for research, they needed to see patients from across the psychiatric spectrum, not simply major mental illness.⁶³ In large part, the Maudsley's admissions policy was driven by the needs of its medical school and research laboratory. Indeed, when Mapother sought funding from the Rockefeller Foundation in 1938 for a neuro-psychiatric wing at the Maudsley, two-thirds of the beds were to be allocated to 'research upon the organic basis of mental disorder' and a third for 'post-graduate and undergraduate education'. 'It is not intended', he emphasised, 'that it should operate as a service to the community . . . but rather would draw selected cases in the first instance from those scattered through the municipal general hospitals'.⁶⁴

The staff ratio of the Maudsley Hospital when it opened in 1923 was noticeably higher than in the county asylums. Edward Mapother, the part-time medical superintendent, had four full-time psychiatrists (A. A. W. Petrie, the Deputy Medical Superintendent, W. S. Dawson, William Moodie and Mary Barkas), supported by a small number of junior doctors in training to serve 157 patients in 6 wards, each of 24 beds. As patient numbers grew, the medical compliment expanded considerably. By 1931, for example, the full-time medical staff had risen to 14 with a part-time female doctor, while the number of trainee psychiatrists had grown considerably.⁶⁵ As a postgraduate medical

⁵⁸BRHA C12/4 Mapother Box 14, Medical Superintendent's Report 1927–1931, p. 10; Jones in Angel (ed.) 2003.

⁵⁹NA MH95/32 E. Mapother 1932 'Memorandum to the Sub-Committee appointed to consider possible developments arising out of the Mental Treatment Act of 1930'.

⁶⁰Stokes 1960, p. 12.

⁶¹Slater 1941, pp. 1–2.

⁶²BRHA C12/4 Mapother Box 14, Clinical Assistants, 1923–37.

⁶³RA RF1.1 401A 19/253 Letter from E. Mapother to Alan Gregg, January 1936.

⁶⁴RA RF1.1 401A 19/254 E. Mapother 'Synopsis of recent and prospective changes at the Maudsley Hospital, c. 1938, p. 1.

⁶⁵NA, MH95/32, Visit of the Board of Control on 8 July 1932, p. 11.

school, the Maudsley had an edge over asylums not only in terms of staffing ratios but also status, a point not lost on the Bethlem Royal, which in 1921 sought to improve the quality of its lecture course and two years later sought affiliation from the University of London.⁶⁶ These advantages probably added to any resentment that the Maudsley selected the most promising patients.⁶⁷

The admission policy set out in 1923 reflected the hypotheses of Mott and Mapother about the cause of mental illness, and what was possible in terms of treatment. Yet, any false optimism about a breakthrough in aetiology was soon dispelled. By 1931, Mapother, who had been sceptical from the outset, reached a grim conclusion: 'as to the grosser form ... of mental disorder ... statistics prove beyond doubt that there has been no improvement either in prevention or cure since dependable figures were obtainable'.⁶⁸ Neither he, nor Aubrey Lewis, who as clinical director increasingly provided the intellectual rationale for the Maudsley, moved very far from Mott's hereditary model. Writing about schizophrenia in 1935, Lewis argued 'constitution, however (seen as the product of interplay between hereditary and environmental influences, acting especially during the most plastic period of development) is of great assistance in judging the probable outcome from a disorder which can itself so profitably be regarded as a manifestation of constitutional failure to achieve an adaptation to the requirements of daily life'.⁶⁹ About manic-depressive psychosis, Lewis took a similar line: 'we infer hereditary and constitutional causes with good grounds, but of the details of heredity in any of the individual forms of mental illness we cannot be sure'.⁷⁰ Furthermore, a follow-up study of 61 cases of depression treated at the Maudsley led Lewis to the conclusion that 'there were no unequivocal prognostic signs, either as to duration of the current attack or as to the subsequent history'.⁷¹

It is not obvious that these observations exercised a significant impact on the hospital's admissions policy in the mid to late 1930s. For example, the proportion of in-patients diagnosed with a psychotic disorder did not change greatly over the inter-war period. Rather, these interpretations did influence the way that patients were treated and the hospital's research agenda. In 1933, when President of the Royal Society of Medicine's Section of Psychiatry, Mapother expounded his strategy for the future in an address entitled 'Tough or Tender: A Plea for Nominalism in Psychiatry'.⁷² In part, Mapother believed that lack of progress evident in 'scientific knowledge concerning psychology and psychiatry' was due 'to distraction from painstaking factual studies of the sort which Kraepelin initiated by the facile charms of animist speculation'.⁷³ He was not impressed by Freudian psychodynamics and firmly resisted any attempt to explain

⁶⁶ Andrews et al. 1997, p. 571.

⁶⁷ A clinical reviewer of this paper commented: 'the view that those psychiatrists graduating from the Maudsley would not have had a broad experience of psychiatry was still prevalent in the late 1980s'.

⁶⁸ RA RF1.1, 401A, 20/263, 'An appeal for an endowment of an Institute of Psychiatry and Psychopathology at the Maudsley Hospital' (typescript, 1931), p. 3.

⁶⁹ Lewis 1935, p. 339.

⁷⁰ Lewis 1936, p. 488.

⁷¹ Lewis 1936, p. 497.

⁷² Mapother 1934.

⁷³ Mapother 1934, p. 1689.

psychosis in terms of unconscious conflict. Having defined nominalism as a doctrine in which 'universals or abstract concepts are mere names without any corresponding realities', he suggested that phenomena, or 'the immediate products of perception', were the only objects of knowledge.⁷⁴

Because of the importance that Mapother attached to objective measures, admissions had to be assessed according to a strict formulation. 'The account of the patient', Slater recalled, 'had to be given in two stages, the history, starting with the family history, and then the physical and mental state at the time of examination; and finally, the patient himself would be seen'.⁷⁵ When visiting the Maudsley from Johns Hopkins University, Adolf Meyer objected to the prominence given to family history because, by emphasising innate factors, 'it only tended to defeat therapeutic optimism'.⁷⁶ Wedded to verifiable facts and opposed to unsupported speculation, this argument met with resistance from Mapother, no changes being made to the presentation of case material.

Mapother believed that the way forward was to develop psychiatry in conjunction with neurology; that the science of the brain was the only legitimate way to understand insanity. Because hypotheses in psychiatry were proposed in the main by clinicians, rather than researchers, who had not the time or inclination to undertake 'the laborious observation and experiment that forms the basis of every progressive science',⁷⁷ this led to overly optimistic expectations of what could be achieved. Mapother advocated an empirical strategy; the collection of data by full-time researchers, he argued, was the only way to reach any understanding of schizophrenia and manic-depression.⁷⁸

Treatment

Economic depression, Grob suggested, failed to dent 'the spirit of therapeutic innovation that had begun with the introduction of fever therapy in the 1920s and continued in the succeeding decade with insulin and metrazol [cardiazol] shock therapy and prefrontal lobotomy'.⁷⁹ Their appeal, he suggests, was related to their scientific gloss and to the fact that only doctors could administer them. In contrast to many asylum psychiatrists, Mapother exhibited a consistent scepticism. In the absence of hard evidence that such treatments did patients any good, he opposed their use. Sargant had to wait for a time when Mapother and Lewis were absent from the hospital before persuading Dr Sinclair, a visiting physician from the Royal Melbourne Hospital, to administer a cardiazol fit to a patient with severe depression.⁸⁰ Because convulsion therapy could produce anxiety and terror, Mapother had banned clinical trials of cardiazol at the Maudsley.⁸¹ Similarly, Slater recalled that Mapother delayed the introduction of insulin-coma therapy until November 1938 because of the serious medical risks attached to what was an unproven intervention. Although doubtful of the dramatic claims, Mapother

⁷⁴Mapother 1934, p. 1690.

⁷⁵Slater 1941, p. 2.

⁷⁶*Ibid.*

⁷⁷Mapother 1934, p. 1711.

⁷⁸RA RF 12.1 Box 49, D. P. O'Brien's diary, record of meeting with E. Mapother, 14 April 1933.

⁷⁹Grob 1983, p. 288.

⁸⁰Sargant 1967, p. 54.

⁸¹McCrae 2006, p. 71.

then arranged for a Swiss physician, expert in the administration of the technique, to instruct Maudsley staff. When the treatment spread to LCC mental institutions, Mapother devised an experiment by which all hospitals would co-operate in a controlled study to test the procedure's efficacy. The plan floundered because some medical superintendents refused to allow any infringement of their autonomy in the question of treatment.⁸² The brake that Mapother placed on the admission of patients with schizophrenia and other severe disorders would plausibly have been relaxed had he been more optimistic about novel treatments.

Some junior doctors, of whom the most vocal were Eliot Slater and William Sargant, thought that Mapother's pessimism led him to set overly modest goals. Slater argued that his blueprint failed 'to give a satisfying picture of the human mind at work in trying to understand the world around, and it fails to give that kind of foundation which feels firm enough to step off from the unknown'.⁸³ Having embraced the physical treatments of the late 1930s—prefrontal leucotomy, insulin-coma and electro-convulsive therapy—Sargant and Slater wrote that the 'inertia, over-cautiousness and therapeutic nihilism' characteristic of 'orthodox psychiatrists' had led them 'to lose sight of the individual life and the happiness or misery of the single patient and his family'.⁸⁴ Like Cotton, they argued that treatment should be radical and applied at the earliest possible opportunity to arrest any degenerative process:

Organic conditions, such as vitamin deficiencies and general paralysis, if allowed to persist for any length of time, produce some scarring from which there can never be complete recovery. The same is true of schizophrenia, and of all psychiatric states it can be said that unfavourable psychological adaptations are the more probable and the more severe the longer the condition is allowed to last. Social reasons for rapidity of treatment are not less important.⁸⁵

Sargant and Slater recommended insulin-coma therapy as the first line of treatment for schizophrenia but proposed prefrontal leucotomy in such cases where 'the disease has reached a quiescent stage' with residual symptoms characterised by 'absorption with abnormal ideas'.⁸⁶

Conclusions

In the immediate aftermath of the First World War, doctors drawn to the new discipline of psychological medicine believed that causes of major mental illness were close to being discovered, holding out the promise of effective preventive measures. Not everyone, however, was swept along by the tide of false optimism and Mapother remained cautious about the chances of finding a cure for psychotic disorders on the grounds that no medical scientist had any 'definite information on the prevention of mental disorder'.⁸⁷

⁸² Slater 1941, p. 3.

⁸³ Slater 1972, p. 594.

⁸⁴ Sargant and Slater 1944, p. 1.

⁸⁵ Sargant and Slater 1944, p. 12.

⁸⁶ Sargant and Slater 1944, p. 141.

⁸⁷ Mapother 1925, p. 785.

In 1921, when the LCC planned for the opening of the Maudsley, it was feared that the strict voluntary criteria might leave the hospital short of patients.⁸⁸ Few, it was thought, would willingly enter a psychiatric hospital given the stigma attached to the asylum system. Although attempts were made to make the hospital appealing to Londoners—in its exterior design, increased expenditure on better quality food and recreational facilities—this enduring concern influenced the admissions policy. In his 1923 interview with the *New Statesman*, Mapother was careful to avoid associations with asylums and, by excluding chronic or unruly patients, sought to create a therapeutic atmosphere. When Medical Superintendent of the hospital in 1920, he had repeatedly complained to the Ministry of Pensions about how aggressive patients not only disrupted treatment but also consumed the attention of both medical and nursing staff.⁸⁹

With little by way of treatment, either in the form of medicines or invasive procedures, Mapother was forced to rely on the environment and social psychiatry to affect improvement in mental health. In this respect, a parallel can be drawn with sanatoria treatments for tuberculosis. Without pharmaceuticals to treat the primary infection and secondary inflammation, physicians relied on diet, fresh air, rest followed by graduated exercise.⁹⁰ Mapother adopted a similar environmental regime:

A patient with serious emotional disturbance should be kept in bed as in the case of a feverish tuberculous patient; open air and sunlight are nearly as important in manic-depressive psychosis, and massage is a useful substitute for exercise. Feeding is the second main essential, and the supply of all vitamins should be adequate.⁹¹

Expenditure on patient meals was raised to improve the quality of the food and every opportunity taken to expose patients to fresh air and exercise: those confined to bed were wheeled on to verandas, while those not so restricted were encouraged to walk in the gardens and use the tennis courts. Invasive procedures ('collapse therapy' or artificial pneumothorax) practised in sanatoriums were as questionable as cardiazol fits, leucotomy and insulin-coma therapy in psychiatry. Mapother and Lewis were rightly suspicious of these risky procedures.

With little to offer patients apart from respite, sedatives and various forms of occupational therapy, Mapother placed his faith in future research. In essence, the Maudsley operated as a postgraduate medical school. Its growing international status attracted both students and grant income. Indeed, Daniel O'Brien, the Rockefeller Foundation's European representative, wrote of the hospital in January 1938 that this status was crucially related to:

a) the number of people doing research and teaching, b) the quality of the men so engaged and c) the productivity in the form of investigation on mental disease in its broad interpretation.⁹²

The transformation in the Maudsley's standing, he observed, had taken place over the last five years. Although the fruits of these academic endeavours were not to be seen until post-1945, the patients of South London had been shielded from the worst excesses

⁸⁸Lewis 1969.

⁸⁹NA PIN15/55, Letters from E. Mapother to Colonel A. W. Sheen, 17 December and 29 December 1919.

⁹⁰Laidlaw 1990.

⁹¹Mapother 1926, p. 876.

⁹²RA RF1.1 401A 19/254, Report from D. P. O'Brien to A. Gregg, 12 January 1938, p. 9.

of optimistic psychiatry. Mapother's achievement was to lay the foundations of a psychiatric service for Londoners while also creating an institution for research and training that met the standards of international medical charities.

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